

VIEWS & REVIEWS

Living in the moment

PERSONAL VIEW **L V Campbell**

“Eyes closed everyone. Just be in the moment. No extraneous thoughts at all, only your own sensations. Stay completely in the moment . . . totally relaxed. Soon you will be able to do this anywhere, any time, without even closing your eyes.”

The soothing voice flowed over the group of overstressed health professionals, who were straining to absorb the latest and the best in stress management. Doctors, nurses, and dietitians were trying hard to capture a feeling normally foreign to health workers: total submission to their immediate sensations. But the simple instructions proved difficult for people coiled as tightly as springs, always ready to face the next challenge or assault. Our enthusiastic young physiotherapist tutor looked disappointed and decided to call it a day earlier than expected. As we filed out he handed out printed summaries for us to study later.

As we emerged from the dim interior the issues of the day descended on us like a toxic cloud, filling our thoughts. Although we knew that most of the problems we wrestle with each day are forgotten in a year, swamped by even greater challenges, crises, and threats, the adrenaline flowed into our veins on cue. Trying to empty my mind had merely opened a set of floodgates through which barely suppressed deadlines and imminent disasters flowed unchecked.

During the session I had left one eye half open to see whether the others were doing any better; a few did seem to be in a calmer place. However, I felt that my burden was greater than theirs, for my domestic demands included caring for my elderly mother, herself once an extremely clever and devoted physician. In advanced age she had progressive memory loss, with all that accompanies it. It is not necessary in a medical journal to describe the profound indignities of the ageing process itself, but the final affront had been her loss of the memory

of everything that mattered in her life. Some have described dementia as being like slipping back into the dependency of childhood—but facing only further undignified decline, not ascent as a child does.

One night I told my mother of the death of a lifelong friend of hers who had had a major stroke. Having watched my mother become unable to recognise even well loved faces or names, I had considered not mentioning the death at all. She often forgets that her friends are dead and is surprised and upset with each reminder. So I wrote a couple of bland, meaningless lines in my mother's name on a suitable condolence card and put it before my her, merely hoping she would sign it legibly. She spent some time writing clumsily and then laid the pen aside. Later, when I put the letter in the envelope I had prepared, my eyes filled with tears as I read the words she had written in a relatively clear hand: “Mollie was my dear friend for many years. We wrote to one another often over the years. I will think of her with love, till I too follow her.”

I expected so little of her, yet she wrote something simple and beautiful. I have copied it and left it on my desk, to remind me for ever (till I myself follow them both) that we never really know everything that lies in any human mind. We feel important in our busy jobs but may still estimate poorly what is in the mind of someone with “limited cognitive abilities.” Some of my “retarded” patients are the emotional heart of their family: one girl with Down's syndrome provides piercing insights into the psychodynamics of her family. As the child of a psychiatrist I spent many childhood years living in mental



hospitals, where I often attended Christmas parties with the long stay patients. It was a life full of delightful experiences for a child with no preconceptions as to who or what is regarded as “normal.” Contributions from mentally “impaired”

people can far exceed our limited expectations of them and give unexpected insights into the brain's plasticity.

I followed my mother onto the balcony. She had wandered out there and sat gazing into the trees and garden as she often does now, watching—and yet not watching—the birds and butterflies darting among the flowers. She spoke little, just following the beauty of a bird soaring down to drink from the fountain or the panther-like progress of our cats through the undergrowth. I followed her gaze and realised that she was “in the moment” in a way I had found impossible at the previous day's session.

It was soon time for me to begin my frenetic working day. I left my mother in the early sunlight, quietly absorbing the sounds of the morning. She, who had once been as anxious, harrowed, and busy a medical professional as any of us, had acquired the elusive art of relaxation very late in life. Perhaps most doctors nowadays are doomed to live an overcommitted, fretful life until the inevitable degenerative processes empty our minds of all thought and we discover a similar enforced type of peace. We must accept that our vulnerability is the same as that of our patients and that we all huddle together under the inevitable blows of fate and time. With the great privilege in medicine of sharing our patients' journeys, we doctors should learn to live more fully the moments remaining to us. Professor L V Campbell is director of the Diabetes Centre, St Vincent's Hospital, Darlinghurst, Sydney, Australia l.campbell@garvan.org.au

Perhaps most doctors nowadays are doomed to live an overcommitted, fretful life until the inevitable degenerative processes empty our minds

Liam Donaldson's
medical classic,
p 563



REVIEW OF THE WEEK

Women, interrupted

Women have been the focus of more psychiatric attention than men over the past 200 years. A new book reviewed by **Gwen Adshead** considers why this is still the case

Mad, Bad and Sad: The History of Women and the Mind Doctors from 1800 to the Present

Lisa Appignanesi

Virago, £20, pp 540

ISBN 978 1 84408 233 9

Rating: ★★☆☆

Some people seem unfairly talented, and Professor Appignanesi is one of them. She is both a historian of ideas and novelist and, together with John Forrester, previously wrote a book entitled *Freud's Women*, about the important female figures in the history of psychoanalysis. Here she returns to the themes of psychiatry, history, and gender, but in a broader context and with a bolder aim: to examine how and why women seem to have been the focus of so much psychiatric attention over the past 200 years and why this is still the case today.

This hugely readable book provides an overview of the historical development of ideas in psychiatry, without superficiality or glib generalisations. The contents include not only remarkable case histories but also discussion of different topics that have generated psychiatric debate in the past, such as sleep, sex, mother-child relationships, and child abuse as a cause of disorder. Many of the case histories are forensic in nature, which made me realise afresh how the history of psychiatry is closely tied to the philosophy and psychology of rule breaking in general, especially in the context of bizarre and violent crime that demands an explanation.

Like all good books this one made me think and want to ask more and related questions. Firstly, it still seems difficult for any type of psychiatric discourse to take male distress seriously: femininity and associated mental problems as alienism have clearly preoccu-

ped psychiatry since its inception, but masculinity and its attendant problems (violence and addiction to name but two) seem to slither away from the medical gaze and retain a dreadful normality.

Secondly, I was struck by how many of the women in the case histories had been exposed to sudden bereavement and losses of important figures, either in childhood or adulthood. The power of grief to disorganise the mind and give rise to pretty much every psychiatric symptom known to classification seems hardly to have been acknowledged by the mind doctors of each time period who dealt with these women. Yet the 19th century had Robert Burton's classic account of melancholy; the 20th had access to the research of John Bowlby and Colin Murray Parkes; and the 21st has Allan Schore's work, setting out exactly how grief, and the loss of attachments, drives people mad. This work may be especially relevant to the question of why women are over-represented in psychiatric populations. If women's autonomy is in some part relational, not indexical—that is, some aspects of their identity are located in external relationships and roles—then (to paraphrase Donne) any person's death diminishes and disorganises some woman's identity.

Lastly, I found myself maddened by the persistent tendency of any psychiatric discourse to embrace reductionist and essentialist theories of how humans work.

Time and again psychiatrists claim to have the found "the" cause of mental distress (especially in women), and this "cause" lies in the uterus, the teeth, the colon, the diet, the unconscious wish to sleep with your father, the conscious wish to be educated or have the vote. All of these at one time or another have been seen as the sole explanation

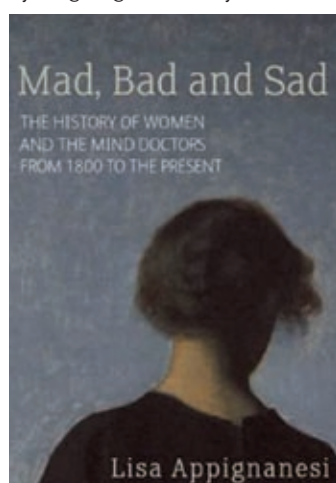
Psychiatrists seem to be drawn to simplistic accounts of experience like extremely dim moths to an artificial light

for female psychological distress and the basis for often quite inhuman interventions called "treatment."

The human mind is arguably the most extraordinary, unusual, and glorious manifestation of organic life on this planet, and yet we still take ordinary mental functioning for granted. Like spoilt children we do not realise what an extraordinary thing mental health is. Equally, we still do not treat mental illness as being a disorder of the most complex biological system: a system that manages to integrate internally and externally generated experience into a consistent whole that is unique to each person. The scale of the complexity is staggering—as is the scale of the disaster when things go wrong. Yet psychiatrists seem to be drawn to simplistic accounts of experience like extremely dim moths to an artificial light.

Appignanesi says something very important at the start of the book. She says that as a historian she is sceptical of present certainties. This seemed to me to be an important message for scientific researchers and therapeutic practitioners in the field of mental distress. It is not likely that there will be one solution to human distress, any more than there is one source of human creativity and joy. Therefore dichotomies such as nature or nurture and genes or environment are not only silly, they are as mad as the pathology they seek to explain. Equally, there is unlikely to be one treatment that suits all, as we will no doubt discover when the money for the "cognitive behaviour therapy for everyone" programme runs out. Taking uncertainty and complexity seriously is something that the human mind is good at; it is only psychiatry that seems sometimes to have been a little reluctant to be this human.

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Bitter sweets

FROM THE
FRONTLINE
Des Spence



We clinicians have a stereotyped view of university academics: bearded cyclists, with sandals and odd terry socks, writing books that no one will read. But our academic comrades can enjoy a moment in the sun. Splashed across the media, a recent meta-analysis of antidepressants concluded, after a reanalysis of unpublished data released through freedom of information legislation, that they are no better than placebo in all but severe cases of depression (*BMJ* 2008;336:466). The study seems to vindicate the position, held by many, that antidepressants are over-prescribed. However, this isn't a time to say "we told you so" but an opportunity to reflect.

Leaving aside the merits (or lack thereof) of the study, why weren't these conclusions available a decade ago? Private companies own the data from trials and have enormous vested interests in controlling access. Therefore, passive suppression of unfavourable results by not publishing them is a legal and legitimate business. Throw in commissioning bias, positive publication bias, and the lack of adequate trial registration and it is hardly surprising that the body of "available evidence" strongly supported antidepressants. Luckily, our researchers are wising up.

But how could "available evidence" translate into 16.2

million prescriptions for selective serotonin reuptake inhibitors (SSRIs) each year? Launched in the early 1990s, SSRIs were widely promoted. The "defeat depression" media campaign ran in the UK from 1992 to 1997, a joint venture of the royal colleges but bankrolled by SSRI manufacturers. GPs were told that "depression is common (one in four patients), recognisable, and treatable." The subtext was that depression was under-recognised and untreated: we were failing patients. Although prescribing antidepressants seemed counterintuitive, we did as we were told. And so began the medicalisation of mood, an unforeseen adverse reaction of evidence based medicine.

How much harm have we done? Plenty. We have accepted under-reported but common withdrawal syndromes and possible dependence issues. But worst of all we have neutered a generation of patients, making them doctor dependent, denying them the opportunity to develop coping strategies, and eroding their self esteem.

What does the future hold? It will give us time to demand full access to all trial data published and unpublished. Respect to the socks and sandals.

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See EDITORIAL, p 516, and FEATURE, p 532

Life at the sharp end

STARTING OUT
Kinesh Patel



Just as we've got used to excuses about the wrong types of leaves on the line and even the wrong type of snow when we wait for a train, we've also now become so accustomed to the wrong type of bureaucracy in the NHS that almost any form of management is resented.

Take venous cannulas, for example—a deeply unglamorous topic, admittedly, and the bane of many junior doctors' lives. A new batch arrived on our ward a couple of months ago, a special safety model that looked pretty much the same as any other cannula. However, when the needle was retracted from the plastic cannula, a metal device clipped over the end to prevent needlestick injuries. The inherent cynic in me then made me try to stab myself with the needle repeatedly, and then I tried to prise off the safety device with an old biro, all to no avail.

Wonderful, I thought. A genuine leap forward, with the potential to abolish instantly all cannula

needlestick injuries. Everyone has attended cardiac arrests or trauma calls where needles are left scattered all over the patient at the end. Who hasn't had a friend or themselves injured by a stray needle?

So, it was with some dismay when I noticed a few weeks later that the old type of cannulas were back. I spoke to the ward sister about this and was met with the response: "Too expensive." And that was the end of the conversation.

About 100 000 needlestick injuries occur in the NHS each year, more than 250 a day. If 100 000 patients (rather than staff) each year were being exposed to other people's blood, how long would it take before this sort of recklessness was remedied? Unfortunately, even though we have a National Patient Safety Agency—issuing directives such as that advising that covering patients in paraffin may make them prone to immolation—the prospect of a similar scheme for staff seems far off. Would British Telecom or ICI

try to economise for the sake of a few pennies when the real potential consequences include contracting fatal illnesses?

This is a prime example of the need for a bureaucracy—where people in power make important decisions affecting the entire organisation in days not years. The reality is that the ward sister has to pay for important safety equipment out of a fixed budget and is castigated for overspending. Of course, any adverse events ("claim sensitive" events in management speak) come out of a separate budget so don't affect those spending the money in the first place.

What will it take for this to change? A scandal more profound than that of healthcare professionals contracting hepatitis C or HIV? Until then, I suppose we just have to be as careful as we can. Because, as we all know, tomorrow it really could be you.

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The plague's the thing

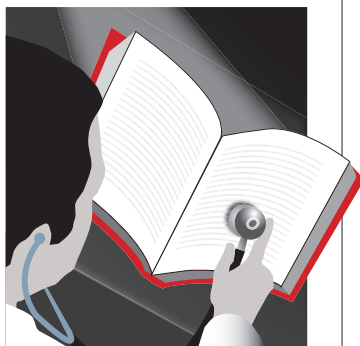
Of all the epidemic diseases, plague is by far the most literary—or perhaps I should say has inspired the most literature, from Boccaccio to Camus. The inspiration of literature was not the only beneficial effect of the disease, however: the Plague Orders of Elizabethan England forbade Sunday indulgence in tippling, gaming, and tobacco taking but, most important of all, prohibited “the outrageous play at the football.” Who, observing any modern English football crowd, could deny that this would be a most excellent thing?

Some scholars maintain that the plague reduced Shakespeare's output and shortened his career. Elizabethan playwrights were like journalists: they wrote only when there was an immediate demand for their work. The playhouses were closed frequently during the Elizabethan and Jacobean period, once the bills of mortality showed that more than 30 or 40 people had died of the plague in the past week.

Other scholars have suggested that the quality of the drama fell with the decreasing frequency of the plague, for there is nothing like impending catastrophe to focus your thoughts on what is important in life. (“Depend upon it, Sir,” said Doctor Johnson, “it concentrates a man's mind wonderfully when he knows he is to be hanged in a fortnight.”) Certainly, Shakespeare's greatest plays were written at a time when plague was at its most frequent, if not quite its most severe.

It is hardly surprising that writers of the time alluded often to a disease that, at regular intervals, killed a tenth to a fifth of the capital's population. If, in *Romeo and Juliet*, Friar John had not been confined in a house that was suspected of harbouring the plague, the all important

BETWEEN THE LINES Theodore Dalrymple



If, in *Romeo and Juliet*, Friar John had not been confined in a house that was suspected of harbouring the plague, the all important letter would have reached Friar Laurence, and Romeo would have got his girl

letter would have reached Friar Laurence, and Romeo would have got his girl. And the most romantic love story would have ended with Juliet pregnant and Romeo deserting her, claiming to need his space because the relationship just wasn't going anywhere.

It is difficult not to believe that Shakespeare's description of the state of Scotland under Macbeth's rule does not make use of the author's experience of London during an epidemic: “Where sighs, and groans, and shrieks that rent the air/Are made, not mark'd: where

violent sorrow seems/A modern ecstasy: the dead man's knell/Is there scarce ask'd for who, and good men's lives/Expire before the flowers in their caps,/Dying, or ere they sicken.”

Oddly enough, the constant death knells got on people's nerves. In Ben Jonson's play *The Silent Woman*, the character Morose, a forerunner of Proust, was so exercised by the “perpetuitie of ringing” that he was led to “devise a roome, with double walls, and treble seelings; the windores close shut, and calk'd; and there he lives by candlelight.”

Of course, our ancestors considered that the plague was God's punishment for their sins, provoked by the popular entertainment of the day, the drama. “The cause of plagues is sinne,” thundered one clergyman, “if you looke to it well: and the cause of sinne are playes: therefore the cause of plagues are playes.”

Luckily, he was wrong. For if television (the “playes” of our time) caused plagues, the bubonic and pneumonic would not be epidemic, they would be pandemically endemic, or endemically pandemic.

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MEDICAL CLASSICS

Profession of Medicine By Eliot Freidson

First published 1970

The fundamental and consistent criterion that distinguishes a profession from other occupations is its autonomy, a condition that is not absolute but that depends for its existence on the tolerance and protection of the state. Eliot Freidson, a giant of medical sociology, drew this conclusion as the central theme of his comprehensive analysis of the nature of professions.

For those who work regularly with medical professional bodies or with doctors in managed care environments, Freidson's monograph, now nearly 40 years old, rings so many bells as to be positively deafening.

Freidson argues that the special privilege of considerable freedom from the control of outsiders rests on three claims by professions. Firstly, that there is such an unusual degree of skill and knowledge involved in professional work that non-professionals are not equipped to evaluate it. Secondly, that professionals are responsible and may be trusted to work without supervision. Thirdly, that the profession can be relied on to deal itself with members who behave incompetently or unethically.

Freidson sees medicine as the archetypal profession. He discusses other attributes of the profession and then moves on to its relevance to the sociology of illness. For, he argues, if a profession is entitled to have ultimate control over the content of its work, the medical profession has heavy influence over determining what illness is and in the creation of illness as a social state.

Doctors unfamiliar with sociological thinking and analysis will find Freidson's arguments very involved, requiring careful study rather than relaxed reading.

Yet this is not a book purely for the student or those with an academic interest. Its power is in the ability to explain the culture, attitudes, and values of the medical profession but also to predict its behaviour. In particular, assessing actions that affect the profession (collectively or individually) and reacting to those actions make perfect sense when seen in terms of the potential threat to autonomy.

Having said all this, the medical profession in Britain (and many other countries) has seen its autonomy constrained greatly over the last two decades: more rigorous standards of practice, a wider base of clinical skills, a broader ethical framework, and new responsibilities to corporate goals and targets in managed care environments. The medical profession has largely adopted and accepted these erosions of its traditional freedom from external control, but perhaps the very process of doing so has contributed to lower morale.

It would be fascinating to debate this changed context with Freidson, but he is no more. His ideas, however, remain an inspiration, and they deserve a place in any debate about the medical profession's future.

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